OR SUMMARIES

Zimbabwe Reproductive Tract Infections

OR Summary 1

RTI Screening Methods for Women Are Not Cost-effective

Existing methods for screening reproductive tract infections among family planning clients are not cost-effective: laboratory tests are too costly, and syndromic case management often leads to missed infections and unnecessary treatment. Health programs should continue to emphasize preventive measures—changing individual behavior and promoting condom use.

Background

Reproductive tract infections (RTIs) are common in Zimbabwe. Many RTIs increase the risk of human immunodeficiency virus (HIV) infection. In 1998, the Zimbabwe National Family Planning Council (ZNFPC) conducted an OR study to assess the feasibility of adding RTI diagnosis and treatment services to its menu of services. The study population consisted of 1,634 clients at three ZNFPC clinics. Each client was asked about lower abdominal pain, vaginal discharge and other RTI symptoms, was examined for clinical signs of RTIs, and was given laboratory tests to confirm the accuracy of diagnosis based upon symptoms and signs.

Findings

◆ **RTI prevalence**. Laboratory tests found that 9 percent of all family planning clients had one or more of the sexually transmitted RTIs (gonorrhea, trichomoniasis, and chlamydia). These three RTIs have serious public health consequences. Most clients with RTIs (26% of all clients) had either candida or bacterial vaginosis, which are not sexually transmitted. Two-thirds of FP clients had none of the five RTIs assessed by laboratory tests.

◆ **Applying clinical guidelines**. The study assessed the use of national guidelines for diagnosing and treating RTIs when laboratory tests are unavailable. Referred to as "syndromic management," the guidelines direct providers to treat with drugs all common causes of the specific syndrome or the combination of clients' reported symptoms and clinical signs observed during a pelvic examination. Identifying RTIs based on the guidelines was not effective because:

✧ Symptoms did not correlate well with RTIs. More than one-third of the clients with one or more RTIs (detected by laboratory tests) had no symptoms, and thus were not diagnosed as infected using the syndromic approach. Conversely, 47 percent of the family planning clients who had RTI symptoms and clinical signs, and therefore were identified as infected under syndromic management, did not actually have any of the five tested RTIs.

✧ Service providers did not always follow the syndromic management guidelines. They treated only 53 percent of the women who complained of lower abdominal pain and 65 percent of those who reported vaginal discharge and had clinical signs of it. The rest of the women went untreated (some were, in fact, uninfected and did not need treatment).

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◆ **Cost of interventions.** None of the interventions studied is affordable to programs in low-resource settings. The lowest-cost intervention is to use syndromic management to evaluate only those FP clients seeking RTI services (see Table). However, this intervention has its drawbacks. In the study 75 percent of RTI cases were undetected and 56 percent of the women treated were misclassified as infected and thus received unnecessary treatment. Laboratory tests provide accurate diagnosis, but they are very expensive.

Policy Implications

◆ Most health agencies in developing countries lack the resources required to implement syndromic management of RTIs on a large scale. For example, in Zimbabwe estimated per capita spending on all health care was US$47 in 1998. Applying syndromic management of RTIs to all FP clients would cost more than 10 percent of these scarce resources.

◆ The ineffectiveness of syndromic approach in identifying women with RTIs calls for a more concerted effort in advocating for and supporting the development of simpler and more cost-effective laboratory tests.

◆ In the absence of more cost-effective approaches to RTI management, ZNFPC and other health agencies need to put greater emphasis on measures to reduce unsafe and unprotected sex, including condom promotion and counseling services to increase clients' perception of personal risk and knowledge of safer behaviors.

December 1999

Accuracy and Cost of Four RTI Diagnostic Models for FP Clients

Diagnostic Model (n = 1,623)	# of Women Correctly Treated	# of Women Given Drugs Needlessly	Total Cost of Drugs and Lab Tests (US$)	Cost per Clinic Client (US$)
Syndromic approach for FP clients seeking RTI services (n = 410)	130	168	4,024	2.48
Syndromic approach for all FP clients	337	298	8,605	5.30
Syndromic approach for all FP clients, with laboratory testing of clients with RTI symptoms and clinical signs	337	0	6,722	10.30
Laboratory testing for all FP clients	524	0	41,819	25.77

Zimbabwe National Family Planning Council. 1999. Demand for and Cost-Effectiveness of Integrating RTI/HIV Services with Clinic-based FP Services in Zimbabwe. *For more information, contact: Population Council, P.O. Box 17643, Nairobi, Kenya. Tel. 254-2-713-480; Fax: 254-2-713-479; E-mail: publications@popcouncil.or.ke.*

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OR SUMMARIES

Mali
Female Genital Cutting

OR Summary 2

FGC Excisors Persist Despite Entreaties

Programs to persuade traditional practitioners to discontinue the practice of Female Genital Cutting (FGC) are ineffective. Interventions must address the demand for FGC rather than focusing on the supply.

Background

About 94 percent (DHS, 1996) of Malian women aged 15-49 have experienced Female Genital Cutting (FGC). In Mali FGC is associated with serious gynecological and obstetric complications.

In 1998 the National Center of Scientific and Technological Research of the Mali Ministry of Secondary and Higher Education and Scientific Research conducted an evaluation of programs to eradicate FGC. The study assessed the work of three national nongovernmental organizations

Excisors continued to perform FGC. Most excisors remained unconvinced that FGC is harmful to women.

(Association Malienne de Suivi et d'Orientation des Pratiques Traditionnelles/AMSOPT, Association pour le Progrès et la Défense des Droits des Femmes/APDF, and Association de Soutien au Développement des Activités de Population/ASDAP) working in Bamako and five regions of Mali. These NGOs had attempted to persuade traditional practitioners of FGC ("excisors") to abandon the practice. Excisors are typically women from the blacksmith caste who come from families recognized by the community as excisors. Family members learn the practice by assisting excisors.

All three NGOs employed outreach workers to educate excisors and community members on the adverse effects of FGC on women's health. Two NGOs developed income generation schemes to provide the excisors with alternative revenues. One NGO sought to train excisors to advocate discontinuation of FGC. Researchers interviewed the heads of the three NGOs, 10 field staff, and 41 excisors. They also conducted 45 focus group discussions with 380 community members.

Findings

◆Nearly all families practice FGC. Ninety-one percent of a nonrepresentative sample of 126 women under age 40 said that they had circumcised their daughters. Nevertheless, the practice may be declining, since 98 percent of the 134 women over age 40 said that they had circumcised their daughters.

◆ Major decision-makers regarding FGC are heads of family groups, religious leaders, the village chief, and grandmothers. Community members defended the practice as a means of continuing cultural traditions, fulfilling religious obligations, controlling female sexuality, and preparing girls for marriage.

◆ Community members and NGO staff reported that the excisors continued to perform FGC, despite their statements to interviewers that they

had abandoned the practice. Excisors who had truly discontinued FGC did so for two major reasons: (1) retirement due to advanced age, poor eyesight, or replacement by their daughter; and (2) the promise of income from alternative activities. Most excisors remained unconvinced that FGC is harmful to women.

FGC eradication programs must reach diverse audiences, including men, opinion leaders, religious leaders, and traditional midwives.

◆ The strategy of converting excisors was ineffective because:

✧ Parents continued to seek out excisors as needed. They also found health workers willing to do FGC.

✧ The low social status of excisors does not put them in a decision-making role to end FGC.

✧ Excisors receive community recognition for their role and thus payments from their work are not their only source of motivation.

Men Talk about FGC

"The world changes. That's why we can now talk about excision with you. Before, no one would want to come to hear you discuss such topics."

"Perhaps our grandchildren will not go for excision. In any case, abandonment will not happen during our lifetime."

— Participants in a focus group discussion

Policy Implications

◆ Programs must focus on reducing demand for FGC from the community, rather than seeking to reduce the supply of excisors willing to do FGC.

◆ NGOs must develop broad-based community education campaigns that promote discussion about FGC and encourage local leaders to speak out against the practice. FGC eradication programs must reach diverse audiences, including men, opinion leaders, religious leaders, and traditional midwives.

◆ Research should focus on designing effective intervention strategies based on reproductive health and human rights, countering arguments made by FGC adherents, and documenting NGO activities.

January 2000

Mali Ministère des Enseignements Secondaire, Supérieur et de la Recherche Scientifique, Centre National de la Recherche Scientifique et Technologique. 1998. Evaluation de la Stratégie de Reconversion des Exciseuses pour l'Eradication des Mutilations Génitales Féminines au Mali. *For more information, contact: Population Council, P.O. Box 21027, Dakar Senegal. Tel.: 221-824-1993; Fax: 221-824-1998; E-mail: pcdakar@pcdakar.org.*

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OR SUMMARIES

Burkina Faso Postabortion Care

OR Summary 3

Upgrading Postabortion Care Benefits Patients and Providers

Training hospital staff to improve emergency medical care for women with miscarriages and unsafe abortions leads to better patient care, shorter hospital stays, lower costs, and increased contraceptive use. Local anesthesia is essential for pain control. Physicians trained to provide postabortion care have trained other medical teams in Burkina Faso as well as in Senegal, Guinea and Haiti. Health officials from other West African countries have expressed interest in PAC training.

Background

At the request of the Family Health Directorate of the Ministry of Health (MOH), the Reproductive Health Research Network (CRESAR) conducted a study during 1996-1998 to introduce emergency care for women with complications from miscarriage or unsafe abortion. With technical assistance from Population Council and JHPIEGO, CRESAR trained staff at two large hospitals in Ouagadougou and Bobo-Dioulasso to provide postabortion care (PAC). Training for physicians, nurses and midwives covered manual vacuum aspiration (MVA), family planning methods, infection prevention, and communication with patients. Staff also participated in the development of policies and standards for PAC services.

To measure changes in knowledge and behavior, CRESAR interviewed 330 patients with abortion complications and 78 providers before the intervention, and 456 patients and 41 providers after the intervention. Information on hospital costs was also collected.

Scaling Up

During the pilot study the MOH, CRESAR, and service providers at the two study sites drafted national policies and standards for PAC services. The standards specify essential components of quality PAC services, such as infection prevention procedures and routine patient counseling. The MOH has adopted these policies and standards and has begun to extend services to regional hospitals.

The four physicians trained during this study have trained other medical teams in regional hospitals in Burkina Faso. They have also trained providers in Senegal, Guinea and Haiti. Health officials from other West African countries have expressed interest in PAC training.

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Findings

◆ Patient satisfaction was significantly higher after improved PAC services were introduced. Nearly all patients stated that providers answered their questions readily and gave clear explanations and instructions.

◆ Nearly all patients (94%) received family planning counseling. After counseling, 83 percent of the patients accepted a contraceptive method, compared with 57 percent before the intervention.

◆ Verbal reassurance alone is inadequate for pain control during MVA. Local anesthesia is essential.

◆ Providers switched to MVA as their preferred treatment for postabortion care. MVA lowered costs for both the hospital and patients due to shorter hospital stays, less anesthesia, and less staff time, compared with previous clinical practices.

Policy Implications

◆ During expansion of PAC services, special attention should be given to quality of care and linkages to family planning services. Costs for MVA equipment and other supplies should be included in hospital budgets.

◆ The hospitals used as study sites can play a key role as reference, training and study centers for other practitioners.

Benefits of Improved PAC Services

	Before Training	After Training
Staff time for emergency treatment (minutes)	73	23
Length of hospital stay (hours)	36	19
Cost to patient (USD)	$34	$15
Patient informed of immediate return of fertility	13%	90%
Patient received FP method	57%	83%

February 2000

Ministry of Health, Burkina Faso, 1988. Introduction of Emergency Medical Treatment and Family Planning Services for Women with Complications from Abortion in Burkina Faso. *For more information contact: Population Council, 128 Sotrac Mermoz,P.O. Box 21027, Dakar, Senegal. Tel. 221-824-1993; Fax: 221-824-1998; E-mail: pcdakar@pcdakar.org.*

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OR SUMMARIES

Senegal Postabortion Care

Train More Providers in Postabortion Care

OR Summary 4

Improving postabortion care (PAC) services benefits patients and reduces costs. Providing PAC services can result in shorter hospital stays, decreased patient costs, better communication between providers and patients, and increased acceptance of contraceptive use by women treated for abortion or miscarriage. Local anesthesia is needed for pain control.

Background

In Senegal, nearly one in five women requiring emergency obstetrical care has had a nonmedical abortion. Recognizing unsafe abortion as a serious health problem, the government adopted a national health strategy in 1997 that aims to halve the number of unsafe abortion cases by the year 2001.

In 1997 the Center for Training and Research in Reproductive Health (CEFOREP) and the Obstetrics and Gynecology Clinic (CGO) at Le Dantec University Teaching Hospital in Dakar introduced new clinical techniques to improve emergency treatment for women with complications from miscarriage or abortion. The CGO and two other teaching hospitals served as pilot sites. Physicians, nurses and midwives at the three sites received training in manual vacuum aspiration (MVA), family planning, and counseling. The United Nations Population Fund and JHPIEGO Corporation provided equipment, logistics support and training.

To measure the impact of the training, CEFOREP interviewed 320 women receiving emergency treatment and 204 providers before the intervention and 543 patients and 175 providers after the intervention. Information on service delivery costs was also collected.

Findings

◆ After training, providers quickly shifted to MVA from other clinical techniques.

◆ Changes in service management reduced hospital stays by nearly half, to an average of 1.2 days. Patient costs dropped by 25 percent, although the cost (CFA 26,700 or US$46) remains high for these patients (see Table).

Expanding access to PAC and improving referral procedures could save more women's lives.

◆ Communication between providers and patients improved. Patients received more information about the treatment and more psychological support. However, verbal reassurances did not reduce the need for local anesthesia for pain control.

◆ After the intervention, the proportion of patients who received family planning counseling doubled. Of those who were counseled, the proportion of women who decided to use a contraceptive method increased from 56 percent to 76 percent.

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Policy Implications

◆Expanding access to PAC and improving referral procedures could save more women's lives. More than two in three of all patients interviewed had visited two or more hospitals before receiving treatment, delaying care for up to 4.7 days from the onset of symptoms.

◆ FP counseling should be systematically provided to all postabortion patients.

◆ PAC training should be extended to more physicians, midwives and nurses. Pain control medication is essential. PAC supplies and equipment should be included in hospital and clinic budgets.

Benefits of Improved PAC Services

	Before Training	After Training
Patients admitted immediately for treatment	55%	69%
Length of hospital stay—2 hospitals	2.3 days	1.2 days
Cost to patient	35,800 CFA (US$61)	26,700 CFA (US$46)
Patients counseled about family planning	18%	34%
Of patients counseled, those who received a contraceptive	56%	76%

February 2000

Centre de Formation et de Recherche en Santé de la Reproduction and Clinique Gynecologique et Obstetricale Chu A. le Dantec, 1998. Introduction des Soins Obstetricaux d'Urgence et de la Planification Familiale pour les Patientes Presentant des Complications Lieés a un Avortement Incomplet. *For more information, contact: Population Council, 128 Sotrac Mermoz, P.O. Box 21027, Dakar, Senegal. Tel. 221-824-1993; Fax: 221-824-1998; E-mail: pcdakar@pcdakar.org.*

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Kenya Postabortion Care

OR Summary 5

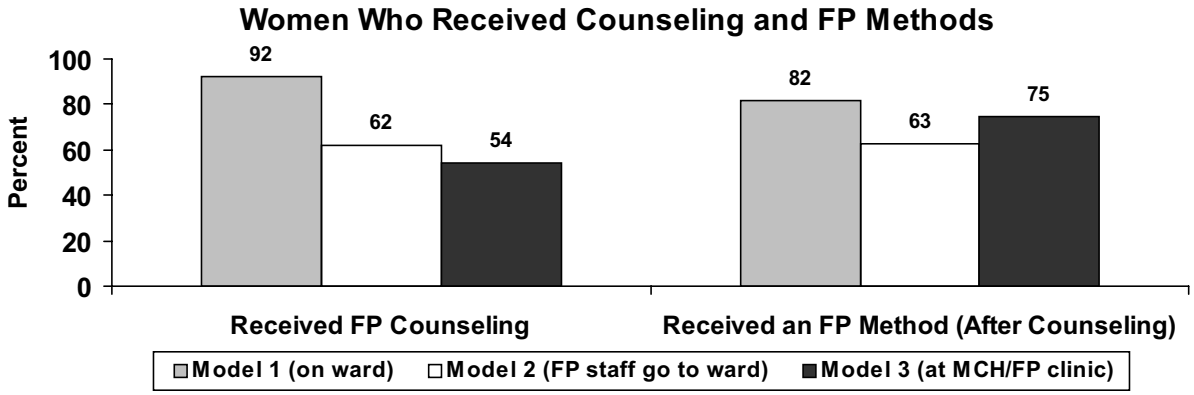
Offer Family Planning on Hospital Wards

The most effective way to ensure that women being treated for incomplete abortion obtain family planning is to offer information and services in hospital gynecological wards, this study concluded. Having ward staff provide contraceptives on the ward is more convenient than having regular family planning providers visit the ward or having patients go to a separate clinic. Findings from this study have been key in informing the expansion plan for PAC in Kenya.

Background

In Kenya, more than one in three women hospitalized for gynecological problems have complications from miscarriage or unsafe abortion. These women generally receive no information or services for family planning or other reproductive health needs.

During 1996-1997, the Kenya Ministry of Health (MOH), Population Council and Ipas collaborated to test three models for providing postabortion care (PAC) and family planning (FP) information and services in two areas of the hospital. The three models are: (1) having gynecology ward staff provide postabortion FP services on the ward; (2) having staff from the maternal and child health/FP clinic provide FP on the gynecology ward; and (3) providing FP at the MCH/FP clinic after PAC treatment but before hospital discharge. Six large district and provincial hospitals served as pilot sites. Researchers compared the effectiveness of the three models by using surveys given before (481 patients and 140 providers) and after the intervention (319 patients, 92 male partners of patients, and 106 providers).



The intervention consisted of: (1) training doctors and nurses in manual vacuum aspiration (MVA) and postabortion FP; (2) providing equipment and supplies; and (3) reorganizing services to better suit patients' needs. All pilot sites designated small rooms for MVA procedures, thus speeding up patient flow and freeing up the main operating rooms. The hospitals offering FP services created private counseling areas on the wards by converting unused space, adding partitions, or reorganizing space. They obtained contraceptive supplies from the hospital's MCH/FP clinic.

Findings

◆ Model 1 – providing postabortion FP information and services on the ward – led to increased adoption of contraception and shorter hospital stays. Under Model 1, more patients actually received FP counseling and services than in the other two models (see graph).

◆ Providers and patients reacted positively to the improved PAC services offered in all three models. Providers preferred MVA to pre-intervention clinical treatment methods. Before the package was introduced, only 7 percent of all PAC patients received FP counseling, compared with 68 percent after the intervention.

◆ In all settings PAC services could be further improved by providing patients with more information. Only 16 percent of the patients were told what to do if problems developed. Similarly, only 41 percent of the patients were warned that they could conceive again soon after abortion. Roughly half of the patients were told about the possible side effects of their chosen method.

◆ Pain control practices remain a problem. Only 3 percent of the patients in both the baseline and post-intervention groups received pain medication, and thus nearly all women reported pain during treatment.

◆ Husbands/partners of patients indicated a strong interest in receiving more information from providers. More than 90 percent of the men interviewed said that they would have liked to know more about their wife/partner's condition and family planning. One hospital began to counsel couples on the gynecological ward.

Policy Implications

◆ Postabortion FP information and services should be offered on gynecological wards by ward staff. Ward staff may need additional training in FP counseling.

◆ Men accompanying PAC patients should also be offered information on their partner's condition and FP counseling, if the woman consents.

◆ PAC providers must provide medication for pain control and should not rely on verbal reassurances alone.

◆ To ensure that PAC services continue, hospital administrators need to ensure that staff are adequately trained and that equipment, supplies, and drugs are available. Both pre-service and in-service training are needed to integrate PAC skills into the existing health system.

◆ Based on these findings, the Kenya MOH developed detailed workplans for expansion of improved PAC services. These plans have now been incorporated into a national strategy to expand PAC throughout Kenya, in both the public and private sector.

February 2000

Solo, Julie, et al. 1998. Creating Linkages between Incomplete Abortion Treatment and Family Planning Services in Kenya: What Works Best? *Also see* Improving Care of Postabortion Patients in Hospitals, *OR Summaries, January 1998. For more information, contact: Population Council, P.O. Box 17643, Nairobi, Kenya. Tel. 254-2-713-480; Fax: 254-2-713-479; E-mail: publications@popcouncil.or.ke.*

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OR SUMMARIES

Peru
Quality of Care

Managers Must Monitor Quality of Care Regularly

OR Summary 6

Family planning providers at Peru's government health facilities conform to national care guidelines in that more than 90 percent of them treat their clients respectfully and offer them a wide choice of contraceptive options. Nevertheless, the majority of providers could further improve the quality of care by giving clients more information about correct use and possible side effects of their chosen method and by screening for contraindications. A 100 percent quality standard ought to be established to avoid violation of individual reproductive rights.

Background

In the late 1980s, Peru's National Family Planning Program within the Ministry of Health (MOH) assigned method-specific targets to clusters of health facilities. In 1998 the MOH changed its policies to ensure that services responded to individual reproductive health needs and wishes. It eliminated method quotas, ended voluntary surgical contraception (VSC) campaigns, and issued norms to ensure quality of care and informed choice.

In 1999 the Population Council collaborated with the MOH to determine whether providers were complying with the new guidelines and, secondarily, to develop a monitoring system to assess compliance over time.

Findings

◆ More than 90 percent of MOH family planning providers treat their clients with respect and provide a variety of contraceptive options without showing bias for or against any particular method.

◆ Nevertheless, MOH providers can do more to ensure that every client receives adequate information about her/his chosen method. For example, most providers warned simulated clients about possible menstrual changes associated with the injectable DMPA, but they did not mention possible delayed conception after discontinuation. Actual clients in exit interviews showed adequate general knowledge about the pill, condom, injectable and VSC. However, specific knowledge concerning the method chosen or used was incomplete.

◆ Most providers in urban health centers did not check simulated clients for three of the four medical conditions that are contraindicated for DMPA use. Few of the providers in health centers gave information on danger signs requiring medical attention.

◆ More than 90 percent of clients who had been sterilized in hospitals stated that they had made the decision themselves or jointly with the provider and 98 percent knew its reproductive consequences.

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◆ *In urban health centers, simulated clients were counseled for 2 to 45 minutes. Providers conveyed 43 percent more information in the 9 to 14-minute sessions compared with 2 to 8-minute sessions.*

◆ *In home interviews, most clients at rural health posts stated that they had made the decision to use contraception, and many had selected a specific method prior to visiting the health post. Rural clients, however, had limited knowledge about their chosen method.*

Policy Implications

◆ *The MOH has produced and circulated new quality of care norms and strengthened its provider retraining efforts and supervision strategies.*

◆ *MOH facilities and individual providers should be evaluated on the quality of their performance and should receive regular feedback.*

◆ *Providers should invest as much time as needed in interactions with clients.*

◆ *A 100 percent quality standard must be established to avoid violations of individual reproductive rights.*

◆ *Two of the five data collection modes – the client exit interview and the use of simulated clients requesting DMPA – proved reliable for monitoring the quality of care in health centers. Monitoring tools for hospitals and rural health posts need further improvement.*

February 2000

Study Design

In order to conserve time and funds, the study used Lot Quality Assurance Sampling to draw a sample of Peru's 6,589 service delivery points. The study sample consisted of 19 hospitals, 19 health centers, and 19 health posts. Six observations were obtained in each facility. Data were collected from June through August 1999 as follows:

- Hospitals were assessed using reports of simulated clients who requested VSC counseling and home interviews with VSC adopters.
- Health centers were assessed using reports from simulated clients who requested the injectable DMPA and exit interviews with family planning clients.
- Rural health posts were assessed through home interviews with clients who had recently started using family planning.

For an element to meet the LQAS standard, at least 95 percent of the six clients interviewed at each facility had to receive specific information or a specific service from the provider in at least 80 percent of the facilities sampled. Parallel analyses were made on the basis of 95 percent confidence intervals in each sample (N = 114).

León, Federico R., 1999. Peru: Providers' Compliance with Quality of Care Norms.

León, Federico R. et al., 1999. Counseling Sessions Length and Amount of Information Exchange in Peruvian Clinics. *For more information, contact: Population Council, Av. San Borja Sur 676, Lima 43, Peru. Tel. 511-475-0275; Fax: 511-475-0675; E-mail: pclima@amauta.rcp.net.pe or contact: Population Council, Escondida 110, Villa Coyoacán, 04000, Mexico, D.F. Mexico. Tel. 52-5659-8537; Fax: 52-5554-1226; E-mail: disemina@popcouncil.org.mx.*

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OR SUMMARIES

Egypt
Access & Quality of Care

OR Summary 7

Family Planning Providers Should Encourage Clients to Discuss Sexual Problems

Both clients and providers welcomed the inclusion of discussions on sexuality during family planning counseling. Providers who were trained in sexuality counseling were more likely to discuss sexual matters with clients. Clients preferred to have the provider initiate the discussion.

Background

This 1999 study, the first of its kind in Egypt, examined the feasibility and impact of introducing discussions of sexuality during family planning (FP) consultations. Conducted by the Population Council in collaboration with the Egyptian Ministry of Health and Population (MOHP), the study took place in four MOHP clinics and two private clinics affiliated with the MOHP. Nurses and physicians at all six clinics attended a two-day training session on contraceptives with an emphasis on barrier methods.

Providers in the three clinics that had been randomly chosen as intervention sites also received three days of training on sexuality, gender and counseling skills. To assess the acceptability of sexuality counseling as well as impact of training, researchers interviewed 25 providers and 503 clients, held five focus group discussions, and debriefed seven "mystery clients" (women who posed as clients).

Findings

◆ Family planning consultations with trained providers were more likely to include a discussion of sexual matters compared with consultations with untrained providers (see Table). More than two-thirds (71%) of the clients who received sexuality counseling said they were not embarrassed to discuss such private issues. The most common sexual problems raised by clients were loss of sexual desire and pain during intercourse. Reports of mystery clients showed that, despite training, providers' technical competence in managing such problems was somewhat limited.

Client Experiences during Family Planning Consultations

Clients who were:	Control (%) (n = 183)	Intervention (%) (n = 320)
Counseled on sexual relations	18	44
Encouraged to ask questions	84	95
Counseled on chosen method's effect on sexuality	22	41
Given a barrier method	2	9

Client Attitudes and Experiences

"If the doctor asks us those [sexuality-related] questions we would tell her about our problems but otherwise I would be embarrassed to tell her."

"I often could not have sex with my husband because of the IUD (bleeding)."

– clients interviewed after clinic visits

◆ Women attending focus group discussions reported various sexual problems related to family planning. Expressing their reluctance to initiate discussion of sexual problems, they said that they would like the provider to ask some routine questions about their sexual relations and indicate a willingness to discuss sexual topics. As confidentiality is a major concern, they prefer to talk with a provider they know, preferably a woman.

◆ Clients at the intervention clinics were more likely than those at the control clinics to receive counseling on the male condom and to obtain a barrier method, mainly condoms. The majority of clients using barrier methods planned to use them for a short time before switching to another method.

◆ Clients at the intervention clinics noticed improvements in the quality of care. They were significantly more likely than clients at the control clinics to report that the provider had encouraged them to ask questions, had provided all the information they were expecting, and had explained how their chosen contraceptive method could affect their sexual relations.

Policy Implications

◆ Sexuality issues, including potential effects of contraceptive options, should be incorporated into family planning counseling. Pre-service and in-service training for providers should include instruction on sexuality, sexual problems, and their relation to family planning methods.

◆ Referrals to teaching or university hospitals should be established.

◆Health education messages should encourage the public to ask family planning providers about concerns and questions regarding sexuality.

March 2000

Abdel-Tawab, Nahla et al., 2000. Integrating Issues of Sexuality into Egyptian Family Planning Counseling. *For more information, contact:Population Council, 6A Giza St., P.O. Box 115, Dokki, Cairo, 12211 Egypt. Tel 20-2-571-9252; Fax 20-2-570-1804; E-mail frontiers@pccairo.org.*

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Indonesia
Institutionalization of OR

OR Summary 8

Coordinated Studies Are Needed to Assess Trends

Longitudinal studies with consistent indicators and representative study populations are needed to identify changes in maternal and child health indicators.

Background

In 1999 the Population Council/Indonesia conducted a critical review of 11 Indonesian surveys and studies that measured various indicators of maternal and child health (MCH) between 1996 and 1999. Many of these studies tried to link these indicators with the nation's economic crisis, which began in July 1997. Council staff sought to explain how these studies came up with divergent findings.

Findings

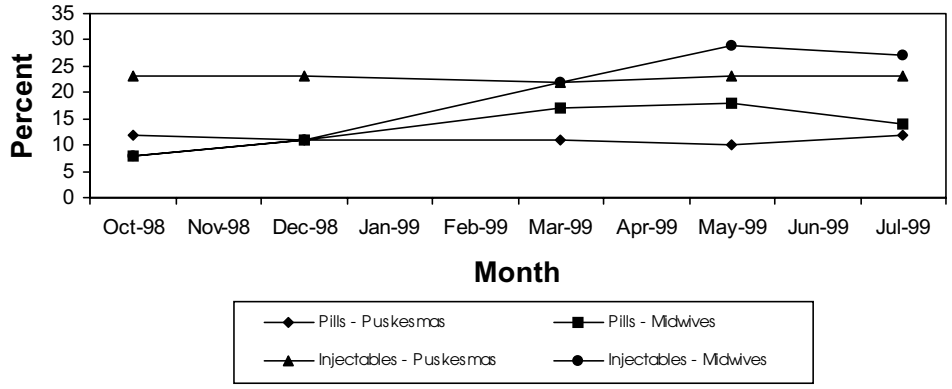
◆ The timing of data collection activities and their geographical coverage are key factors leading to differences in findings.

◆ Data need to be disaggregated to the lowest level possible in order to ascertain differential impacts across regions, among socio-economic and age groups, and by gender and urban/rural residence.

◆ Attributing changes in MCH indicators to the economic crisis may be misleading. Health and nutritional status appears to have been declining before the crisis began. The overall impact of the economic crisis may not be reflected in MCH indicators for several years.

◆ Family planning services experienced some disruptions during 1997-1999. The price of contraceptives rose in late-1997 and early 1998 and fluctuated greatly between mid-1998 and mid-1999. Clinics reported a significant increase in stockouts of contraceptives between 1997 and 1998. During October 1998 through July 1999 stockouts in primary health centers and at

Figure 1. Contraceptive Stockouts

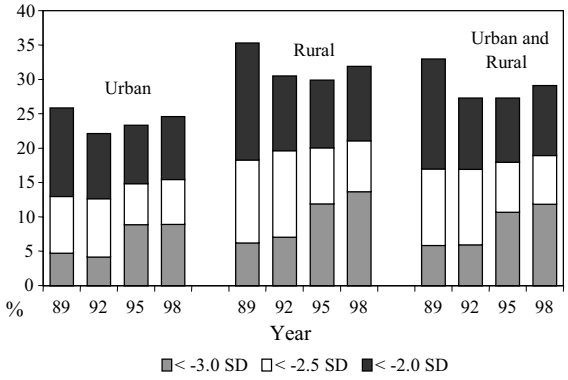


midwives' clinics remained at relatively high levels (see Figure 1). Nevertheless, contraceptive prevalence and the number of health facilities offering contraception did not change significantly during 1997-1999.

◆ The incidence of sexually transmitted infections increased from 1997 to 1998, but it is unclear whether this trend is related to the economic crisis.

◆ The proportion of urban and rural children aged 6-17 months who were underweight – a sign of chronic malnutrition – was higher in 1998 than in 1995 (see Figure 2).

Figure 2. Percent of Children Aged 6-17 Months with Low Weight-for-Age, 1989-98



Policy Implications

◆ Government and nongovernmental agencies, donors, and researchers need to coordinate the planning of key research studies to ensure that comparable and useful measures are developed.

◆ Program planners and other decision-makers must take into account the limitations of each dataset before making generalizations to a wider population or linking health indicators to socio-economic trends. They also need to understand that the various data collection methods have different advantages and disadvantages.

◆ To ensure that research findings are useful to program managers and planners, researchers should make sure that findings, research methodology and sample size are reported accurately and that indicators are comparable in time-series studies. In order to distinguish new trends from short-term fluctuations, researchers should analyze at least three data points and use trend analysis techniques. Tests of statistical significance are essential in order to identify true differences between groups.

March 2000

Gardner, Michelle and Lila Amaliah, 1999. Analysis of Conflicting Crisis-related Research Results. *For more information, contact: Population Council, Sanga Rchana, 53, Lodi Estate, 3rd floor, New Delhi, 110003, India; Tel. 91-11-461-10912; Fax 91-11-461-0912; E-mail: frontiers@pcindia.org; or Population Council Indonesia, Menara Dea Building, Suite 303, Jl. Mega Kunigan Barat Dav. E4.3, No. 1, Jakarta, 12950; Tel. 6221-576-1011; Fax: 6221-576-1013; E-mail: pcjkt@cbn.net.id.*

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OR SUMMARIES

Kenya Reproductive Tract Infections

OR Summary 9

Identifying RTIs Remains Problematic: Prevention Is Essential

More than half of the family planning and antenatal clinic clients in Nakuru, Kenya had one or more reproductive tract infections (RTIs). Roughly one-third of these infections were sexually transmitted. Using syndromic management algorithms based on the woman's reported symptoms, providers correctly classified only 5 to 16 percent of women who later tested positive with laboratory results. Given the limitations of syndromic management, programs need to stress prevention of sexually transmitted infections (STIs).

Background

Since 1990 the Nakuru Municipal Council has implemented a multifaceted program to reduce the incidence of reproductive tract infections, especially those that are sexually transmitted, including HIV/AIDS. Staff in the Council's five health clinics use syndromic management guidelines, based on clients' reported symptoms and clinical signs, to identify clients with RTIs.

In 1998 the Population Council conducted a study to assess the accuracy of syndromic management and determine the best ways to integrate RTI management into existing antenatal (ANC) and family planning (FP) services. Sources of data included: (1) findings from a medical examination, including a pelvic exam and assessment of symptoms and clinical signs, of 906 FP clients and 815 ANC clients; (2) clients' (and their partners') risk factors for STIs; (3) laboratory tests for five RTIs; and (4) interviews with 18 nurses and 195 clients. After an assessment of existing RTI services, 18 nurses from the five municipal clinics attended a three-day refresher course in syndromic management, including training in using a checklist for client management.

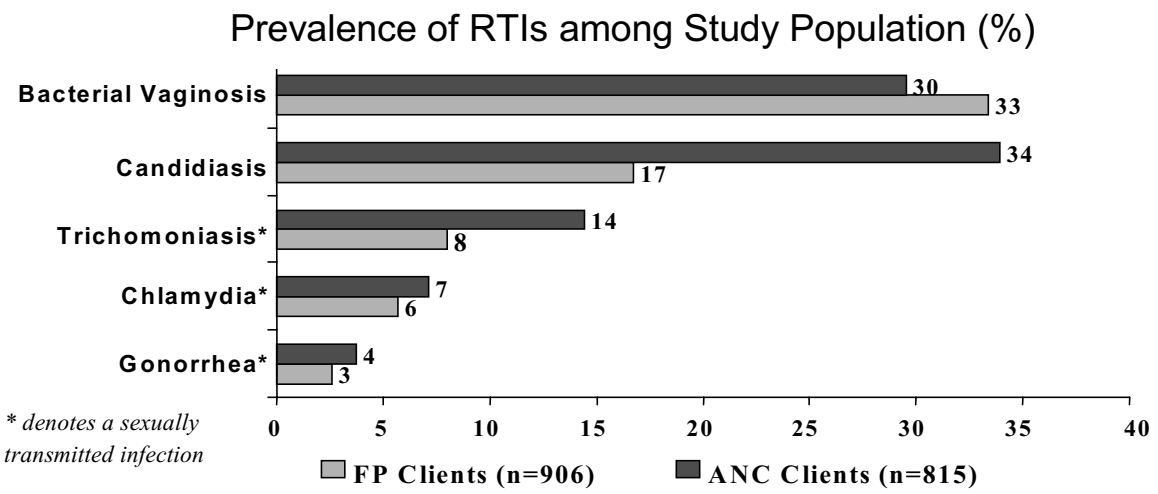
Findings

◆ Fifty percent of FP clients and 59 percent of ANC clients had at least one RTI, as detected by laboratory tests. A relatively high proportion of clients – 14 percent of the FP clients and 21 percent of the ANC clients – had one or more sexually transmitted infections (chlamydia, gonorrhea, and trichomoniasis).

◆ Vaginal infections due to bacterial vaginosis, trichomoniasis and candidiasis were more common (47% FP and 56% ANC clients) compared with cervical infections due to gonorrhea and/or chlamydia (7.5% of FP and 9.4% of ANC clients).

◆ Most women found to have an RTI through laboratory testing were asymptomatic and showed no clinical signs. Only 23 to 29 percent of ANC and FP clients with infection reported one or more RTI symptoms, and 37 to 43 percent of infected clients were found on examination by a provider to have clinical signs.

◆ Applying syndromic management guidelines, providers were able to classify correctly as



infected only a small proportion of the women who actually had a laboratory-diagnosed RTI (5% of the FP clients and 16% of the ANC clients).

◆ Current syndromic management guidelines for women classified as having vaginal discharge syndrome are more reliable for managing women who have a vaginal infection than for managing women having a cervical infection. Most women classified by providers as having a vaginal discharge syndrome (61% of FP clients and 70% of ANC clients) did in fact have a vaginal infection, whereas only 11 percent of FP clients and 8 percent of ANC clients classified as having vaginal discharge syndrome had a cervical infection.

◆ Collecting STI risk assessment information from clients did not significantly improve providers' ability to identify women with cervical infections.

Policy Implications

◆ Given the poor performance of syndromic management for women presenting with vaginal discharge as a symptom of an STI, programs need to emphasize treatment, by improving providers' counseling skills and encouraging them to educate clients about STI symptoms and preventive measures, especially dual protection.

◆ If programs insist on continuing to use syndromic management of vaginal discharge, then women classified by providers as having vaginal discharge syndrome should be first treated as having a vaginal infection (i.e. bacterial vaginosis, candidiasis and trichomoniasis) rather than a cervical infection. If symptoms persist, treatment for cervical infection may be advisable.

◆ Algorithms for managing vaginal discharge need to be reviewed to emphasize treatment for bacterial vaginosis, which is the most common RTI and has been associated with increased risk for HIV infection and pelvic inflammatory disease.

March 2000

Solo, Julie; Ndugga Maggwa; James Kariba Wabur; Bedan Kiare Kariuki; and Gregory Maitha. 1999. Improving the Management of STIs among MCH/FP Clients at the Nakuru Municipal Council Health Clinics. *For more information, contact: Population Council, P.O. Box 17643, Nairobi, Kenya. Tel. 254-2-713-480; Fax 254-2-713-479; E-mail: publications@popcouncil.or.ke.*

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OR SUMMARIES

Burkina Faso and Mali FGC

Female Genital Cutting Harms Women's Health

OR Summary 10

Women in Burkina Faso and Mali who have had their genitals cut are more likely to have gynecological and obstetrical problems, including bleeding, internal scarring, vaginal narrowing, and complications during childbirth. More severe cutting increases a woman's risk of other reproductive health problems.

Background

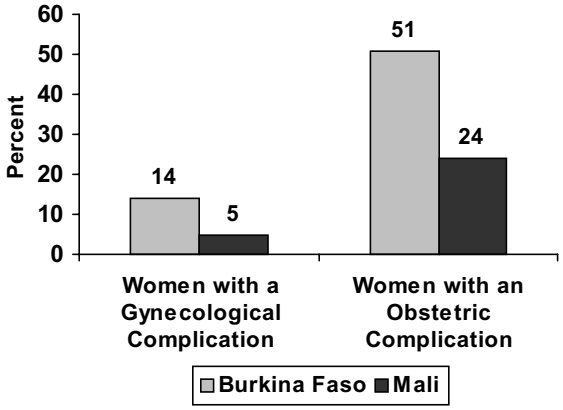
In collaboration with the Ministries of Health (MOH) of Burkina Faso and Mali, the Population Council conducted two studies in 1998 to describe the occurrence and severity of health problems related to female genital cutting (FGC). This traditional practice entails partial or total removal of girls' external genitalia.

Study participants were consenting women who received a pelvic exam during prenatal, family planning, obstetric, or gynecological consultations at MOH clinics. Providers were trained to observe the types and complications of FGC. In order to assess their potential role as change agents, providers in Mali also received training on the health effects of FGC and client counseling. In Burkina Faso, health providers recorded information on and interviewed 1,920 women at 21 health centers in the rural provinces of Bazèga and Zoundwèogo. In Mali's Bamako district and Ségou region, providers recorded information on 5,390 women in 14 urban and rural health centers.

Findings

◆ The prevalence of FGC was very high – 93 percent of the clinic clients in Burkina Faso and 94 percent in Mali had been cut. In Burkina Faso, Type 1 (removal of the clitoral hood and/or clitoris) was most common. Nearly three-fourths (74%) of the women in Mali had Type 2 (clitoridectomy and removal of the labia minora). Five percent of women in both groups had the most severe form of FGC, Type 3 or infibulation, which entails partial or complete removal of the external genitalia with stitching or narrowing of the vaginal opening. FGC was found among all ethnic groups.

Health Complications of FGC*



** Based on client reports in Burkina Faso and actual deliveries in Mali.*

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◆ Fourteen percent of the clients in Burkina Faso and 5 percent of those in Mali had at least one gynecological complication related to FGC. In Burkina Faso, where the majority of women have Type 1 cutting, keloid scarring and vaginal stenosis (narrowing of vaginal walls due to scarring) were the major complications reported by women. In Mali, where Type 2 cutting predominates, hemorrhaging from scar tissue was the major complication observed by clinic staff, followed by vaginal scarring and obstruction.

◆ In both countries, women who were infibulated (Type 3) were almost two and a half times more likely to have a gynecological complication than those with a Type 2 cut. Similarly, women with a Type 1 cut were much less likely to have a complication than those with more severe cuts.

◆ FGC was found to be a major risk factor for complications during childbirth, with risks increasing according to the severity of the cut. In Burkina Faso, cut women were three times more likely to report having had a difficult delivery than uncut women. Women with Types 2 or 3 cutting were more likely to experience hemorrhaging or perineal tearing during delivery.

◆ Among the women in Mali who gave birth at the clinic, 29 percent of those who had been cut experienced complications during childbirth, compared with 7 percent among those who had not been cut. In Mali, 5 percent of uncut women experienced complications during delivery compared with 18 percent of women with Type 1 cutting, 30 percent of those with Type 2, and 36 percent of those with Type 3.

◆ In Burkina Faso, cut women were 1.5 times more likely than uncut women to show signs of genital infection, particularly vaginal discharge, suggesting that FGC may render women more susceptible to RTIs.

Policy Implications

◆ All health personnel should receive information on the serious health problems associated with FGC.

◆ In addition to women's rights issues, information on the deleterious health effects of FGC should be used in community education campaigns.

◆ People assisting women giving birth should anticipate the possibility of FGC-related complications.

March 2000

Diop, Nafissatou J., et al. Etude de l'Efficacité de la Formation du Personnel Socio-sanitaire dans l'Education des Client(e)s sur l'Excision au Mali. *Bamako, Mali: Population Council, 1998.*

Laboratoire de Santé Communautaire du Bazèga. Evaluation de la Prevalence, de la Typologie, et des Complications Liées à l'Excision chez les Patientes Frequentant les Formations Sanitaires du Bazèga. Ougadougu, *Burkina Faso: Population Council. 1998.*

Jones, Heidi, et al. Female Genital Cutting and its Negative Health Outcomes in Burkina Faso and Mali. *Studies in Family Planning Vol. 30, No. 3, September 1999. For more information, contact Population Council, P.O. Box 21027, Dakar, Senegal. Tel. 221-824-1933; Fax 221-824-1998; E-mail: pcdakar@pcdakar.org.*

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OR SUMMARIES

Mali
Female Genital Cutting

OR Summary 11

Empower Health Workers to Advocate against Female Genital Cutting

Health providers are an important potential resource in campaigns to eradicate female genital cutting (FGC), but a concerted effort is needed to ensure that they can become effective behavior change agents. After a three-day training course, providers' knowledge about FGC increased, but few of them counseled their clients about FGC.

Background

The various initiatives to eradicate FGC in Mali – public education campaigns and conversion of traditional excisors – over the past two decades have had little impact on this traditional practice. This study assessed the use of health personnel to combat FGC, as recommended by the World Health Organization.

Conducted in 1998 by the Association de Soutien au Développement des Activités de Population (ASDAP), a nongovernmental organization, and the Ministry of Health, the study covered 14 urban and rural health centers in Bamako and Ségou region. In the eight health centers that served as experimental sites, 59 health providers, including physicians, midwives, nurses and aides, attended a three-day training course on identifying and treating medical complications related to FGC and counseling clients about FGC. In the six centers that served as control sites, 48 providers were interviewed.

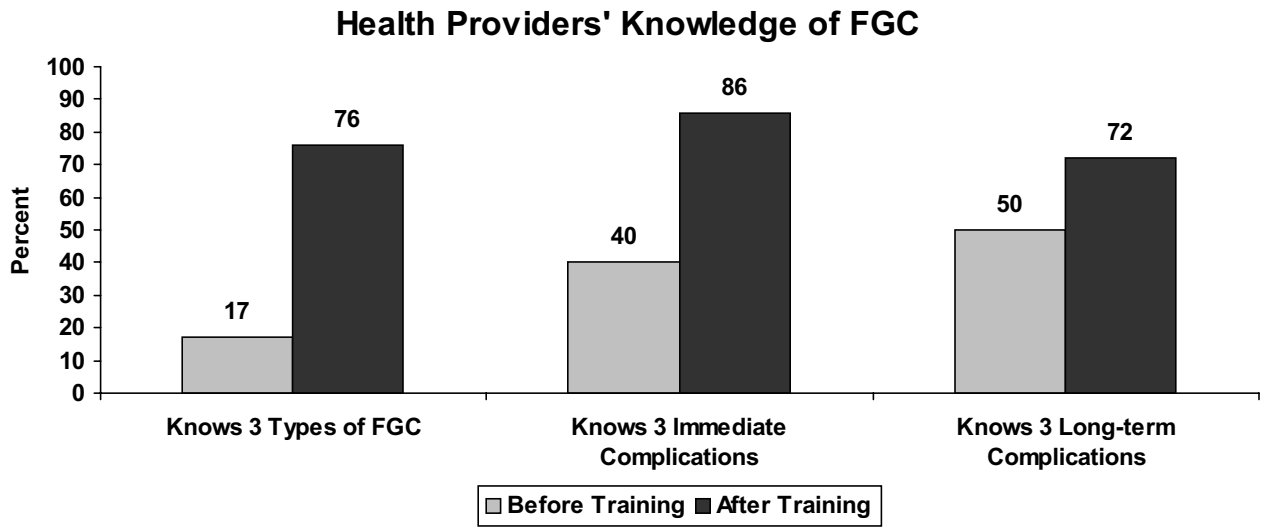
Findings

◆ Nine in ten health providers are opposed to FGC and are willing to play an active role in educating their clients about FGC.

◆ Nevertheless, some providers support the medicalization of FGC. Nine percent of the providers who had been trained and 29 percent of those in the control group stated that FGC presents no health risk if performed in hygienic conditions. Thirteen percent of the 107 providers interviewed admitted that FGC is being practiced at their facility. Four providers said they had performed FGC procedures.

◆ Training did change some providers' attitudes regarding FGC. Before training, 39 percent of providers thought that an uncut girl had loose morals; after training, 26 percent still held this belief. The proportion of providers who thought that men prefer to marry women who have been cut declined from 32 percent to 28 percent, while the proportion who thought that FGC guarantees a girl's virginity decreased from 14 percent to 9 percent.

◆ Providers' knowledge of FGC increased dramatically after training. Roughly three in four trained providers knew at least three immediate and long-term complications (see Figure). However, providers were uncomfortable discussing FGC with their clients and felt too rushed due to the large volume of clients during the morning clinic sessions. Group health talks were held in only two of the eight experimental



clinics. Only six of the 1,105 clients interviewed were counseled about FGC.

◆ The majority of health providers have provided treatment to girls with complications following FGC. More than one third had to refer a client for further treatment of FGC complications. Nevertheless, providers acknowledged that they have limited competence in caring for FGC complications, even after training.

Policy Implications

◆ Mali's MOH is using the study results to develop a new curriculum to promote standardized, mandatory training on FGC for all health providers.

◆ Based on the study findings, the MOH issued a policy banning the practice of FGC in its facilities.

◆ The three-day training course was effective in changing provider attitudes toward FGC, but additional training in communication skills is needed to overcome providers' reticence to discuss FGC with their clients.

◆ To eradicate FGC, community education initiatives are needed in addition to clinic education.

April 2000

Diop, Nafissatou J., et al. Etude de l'Efficacité de la Formation du Personnel Socio-sanitaire dans l'Education des Client(e)s sur l'Excision au Mali. *Bamako, Mali: Population Council, 1998. For more information, contact Population Council, P.O. Box 21027, Dakar, Senegal. Tel. 221-824-1933; Fax 221-824-1998; E-mail: pcdakar@pcdakar.org*

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OR SUMMARIES

Egypt Postabortion Care

Expand Access to Postabortion Care

OR Summary 12

Training providers and introducing a case management protocol led to improved postabortion care at 10 government and teaching hospitals in Egypt. Patients reported shorter waits and greater satisfaction with the medical services they received. Physicians adopted treatment methods associated with fewer complications and provided more health-related information to patients.

Background

The Population Council has supported a series of studies to improve the quality of postabortion care (PAC) in Egypt. A 1994 pilot study in two Egyptian hospitals showed that upgrading PAC and training physicians in manual vacuum aspiration (MVA), infection control and counseling led to significant improvements in the care of postabortion patients. Studies have shown that MVA with local anesthesia is associated with lower complication rates and shorter patient stays than sharp curettage with general anesthesia.

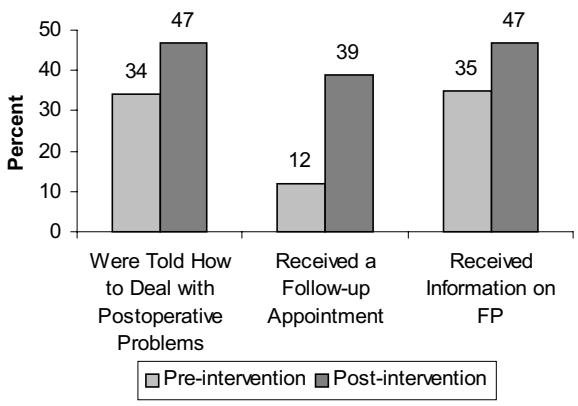
This 1997 study, conducted by the Egyptian Fertility Care Society with support from the Population Council, sought to institutionalize improved postabortion medical care and counseling procedures in ten hospitals – seven government hospitals and three university hospitals. Five senior physicians from each hospital attended a five-day training course in MVA, infection control, and family planning (FP) counseling. The physicians then supervised four months of on-the-job training of doctors and nurses at the 10 hospitals. A case management protocol, including emergency medical treatment, pain control, and FP counseling, was also introduced.

Researchers measured the resulting changes in knowledge and practice by administering surveys before (255 physicians, 311 nurses, and 508 patients) and after (246 physicians, 263 nurses and 497 patients) the intervention. Data were also collected from 1,036 medical records.

Findings

◆ After their training physicians had significant gains in knowledge about short-term complications, adverse health impacts of unsafe abortion, and the immediate return of fertility following postabortion treatment. Physicians were more likely after the intervention to recognize that PAC patients should receive information about the cause of miscarriage and the need to eat well, rest and use contraception during recovery.

Care of Postabortion Patients



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OR SUMMARIES

Peru
Quality of Care

OR Summary 13

Tell Clients How to Use Their Chosen Method

Family planning providers in Peru need to focus more closely on giving clients relevant information on their chosen method and asking key questions in order to make the most efficient use of the time available for client counseling.

Background

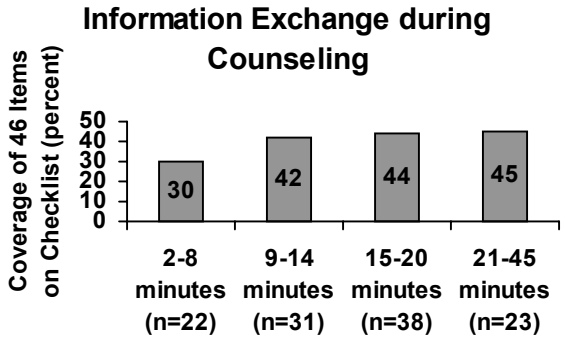
In 1998 the Peruvian Ministry of Health (MOH) issued quality of care norms to ensure that family planning providers respond to their clients' reproductive health care needs and goals. In mid-1999 the Population Council collaborated with the MOH on a study to determine whether the length of counseling sessions affects the amount of information provided to the client.

Using Lot Quality Assurance Sampling, the study focused on 19 health centers in 10 urban areas, drawn from a national sample of 172 facilities. Six simulated clients (women posing as clients) made a total of 114 visits to the 19 health centers during June-July 1999. Each simulated client was trained to say that she wanted to switch from the rhythm method to a more effective method. After counseling, she chose the injectable Depo-Provera but stated that she wished to consult her husband before beginning use.

To assess the quality of counseling, the simulated clients completed a checklist after each visit, indicating what information had been given to them. The checklist consisted of 46 items reflecting optimal information exchange. It covered: questions to identify factors relevant to contraceptive options; information on available contraceptive methods; questions to screen for contraindications to injectable use; information about injectable use, side effects and warning signs; use of barrier methods for temporary protection against pregnancy; and follow-up instructions.

Findings

◆ Providers conveyed more information during sessions lasting nine minutes or longer, compared with shorter sessions. During the sessions lasting 9-14 minutes, providers covered 42 percent of the 46 items on the information exchange checklist, compared with 30 percent of the checklist items during shorter sessions of eight minutes or less. However, information exchange improved only slightly during counseling sessions lasting 15-45 minutes.



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◆ Longer counseling sessions did not lead to more information exchange because the providers spent the extra time giving clients more details about methods they were not planning to use, rather than giving them essential information on use of their chosen method and screening for contraindications. In fewer than 20 percent of the visits, providers asked about vaginal bleeding, discussed breast cancer, advised interim use of barrier methods, or asked whether the client understood.

◆ Nevertheless, providers are meeting many quality of care goals. In more than four in five counseling sessions, providers asked standard questions needed to assess appropriate contraceptive options, discussed four or more contraceptive methods, and asked the client to make a choice of methods.

◆ Providers involved in the study welcomed the feedback regarding the quality of their counseling. They cited time constraints as the major cause of insufficient counseling. Some visits were clearly too short, but the average visit lasted 15 minutes, which should have been sufficient to cover key information. Researchers concluded that providers could have used their counseling time more efficiently. Also, they missed opportunities to provide client-centered treatment by asking questions to ascertain each client's situation and needs.

Policy Implications

◆ The MOH should test an alternative model for client counseling in order to help providers to give more effective, client-centered family planning counseling. This model consists of five steps:

1. A warm welcome;
2. A client-centered diagnosis that identifies a subset of appropriate family planning methods;
3. Provision of appropriate, personalized information on appropriate methods, leading to choice of a single method;
4. Screening for contraindications, education on use of the method chosen, and instructions for follow-up; and
5. Feedback to ensure understanding and appropriate follow-up.

This model should stress the provider's role after a contraceptive method has been chosen, including screening for contraindications, giving instructions on correct use, and discussing side effects and warning signs. The MOH should develop job aids to help providers implement this model and should undertake operations research to assess its value.

September 2000

León, Federico R. et al., 1999. Counseling Sessions Length and Amount of Information Exchange in Peruvian Clinics. *For more information, contact: Population Council, Av. San Borja Sur 676, Lima 43, Peru. Tel. 511-475-0275; Fax: 511-475-0675; E-mail: pclima@amauta.rcp.net.pe or contact: Population Council, Escondida 110, Villa Coyoacán, 04000, Mexico, D.F. Mexico. Tel. 52-5659-8537; Fax: 52-5554-1226; E-mail:* disemina@popcouncil.org.mx.

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OR SUMMARIES

Egypt
FGC

NGOs Need to Join Forces to End FGC

OR Summary 14

Fifteen Egyptian non-governmental organizations are actively involved in programs to eradicate the practice of female genital cutting. To make these programs more effective, NGOs should form coalitions, engage in advocacy, train activists in communication skills, and evaluate the impact of their programs.

Background

Until recently, the practice of female genital cutting (FGC) has been nearly universal in Egypt. However, a 1998 national survey found the first signs of a decline in the practice among adolescents since 1994 (El-Gibaly et al., 1999).

Non-governmental organizations (NGOs) working in community development, health and women's rights have played a leading role in advocating eradication of FGC in Egypt. To document and assess the impact of anti-FGC programs, the Population Council conducted an assessment from August 1999 to February 2000. Researchers telephoned numerous Egyptian NGOs to identify those most actively involved in anti-FGC programs. Then they conducted in-depth interviews with officials of 15 NGOs.

as well as staff of the Ministry of Health and Population, UNICEF and the United Nations Population Fund (UNFPA).

Findings

◆ Most NGOs had no evaluation mechanism in place to assess the impact of their interventions. Some NGOs collect information on process indicators, such as the number of meetings, attendees, and requests for information. Few NGOs measure the impact of their interventions on participants' knowledge, attitudes, or practices.

◆ Each of the four basic intervention models identified in the assessment was useful in addressing some aspect of the behavior change continuum, from creating awareness to increasing knowledge, to talking with others about FGC, culminating in the decision to take a firm stand against FGC. The four intervention models are:

✦ **Awareness-raising**. Many NGOs have organized large lectures and seminars for community members, with medical and religious leaders discussing the harmful effects of FGC. Such meetings reach large numbers of people at a relatively low cost.

✦ **Community members as change agents.** Some NGOs have trained influential community members or individuals who are opposed to FGC (positive deviants) to talk to others in their

community. NGO leaders reported that this approach did lead to knowledge gains and attitude change regarding FGC.

✦ **Community development**. Several NGOs have integrated anti-FGC messages into literacy classes and a program for handicapped youth. A few NGOs have added anti-FGC components to their comprehensive development programs. This approach is promising, since it targets the entire community and reaches individuals through multiple channels such as seminars, home visits and literacy classes. However, it is expensive and labor-intensive.

✦ **Advocacy**. A few NGOs have done advocacy work such as: organizing meetings of government officials; providing information to politicians, researchers and journalists; building coalitions with other NGOs; training local leaders in advocacy skills; and producing radio and television programs on FGC.

◆ Although most NGO officials recognized the importance of networks and coalitions for combating FGC, only two NGOs belong to such groups.

Policy Implications

At a two-day seminar held in January 2000 in Cairo, 40 representatives of NGOs, government agencies, research institutes, donor agencies, and Cooperating Agencies discussed the assessment findings and recommended that:

◆ NGOs should form coalitions to reinforce and complement each other's work. They should involve government agencies, media outlets, research institutions, and communities in broad-scale interventions.

◆ More advocacy activities, particularly those that combine media and policy activities, are needed to create a strong social and political environment against FGC in Egypt.

◆ Anti-FGC messages should discuss social, religious and legal perspectives rather than focusing on the health hazards of FGC.

◆ NGOs should develop partnerships with research institutions to obtain technical assistance in evaluation. They should develop indicators to measure the different stages of attitude and behavior change.

◆ Outreach workers and community advocates need training in communication techniques and problem-solving skills, assistance in defining their activities, and better supervision.

September 2000

Abdel-Tawab, Nahla, and Sahar Hegazi.2000. "Critical Analysis of Interventions against FGC in Egypt." *Cairo: Population Council. For more information or to obtain a copy of the English Final Report or the Arabic Condensed Summary of this study, contact: Population Council, 6A Mohamed Bahie Eddine Barakat St., 10th floor, Giza, Egypt. Tel.: 202-571-9252; Fax: 202-570-1804; E-mail:* **frontiers@pccairo.org** .

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OR SUMMARIES

Egypt Dissemination

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Encourage Journalists to Cover Reproductive Health

After Egyptian print journalists attended a series of briefings on reproductive health issues, their reporting of these issues improved. Health agencies can improve coverage of reproductive health issues by providing a regular flow of accurate information to a broad range of journalists.

Background

To raise public awareness of reproductive health (RH) issues, the Population Council FRONTIERS project and the Futures Group POLICY project jointly organized press briefings and provided background materials to key journalists from Arabic newspapers and magazines. From May 1999 to June 2000, project staff worked closely with 20 Egyptian journalists, including editors of women's pages and senior editors. The four press briefings covered youth, marriage patterns, contraceptive technology, and menopause. The press kit prepared for each briefing contained fact sheets, reference materials, a contact list of key experts, and an evaluation sheet.

To assess RH reporting and track coverage resulting from the intervention, project staff monitored eight major Arabic newspapers and nine magazines daily. All articles on RH were coded according to their topic, length, and use of research findings.

Findings

◆ The press briefings did generate press coverage. Of the 433 RH articles published in newspapers from May 1999 through March 2000, one-fifth covered topics featured in the press briefings. Similarly, one-third of the 127 magazine articles identified covered press briefing topics.

"The numbers and figures presented … will have a more effective impact on public opinion." *–Participating journalist*

◆ Journalists attending the press briefings reported that their knowledge of RH issues increased and that they planned to use the press kits to write their articles. Some journalists shared the press kits with their colleagues.

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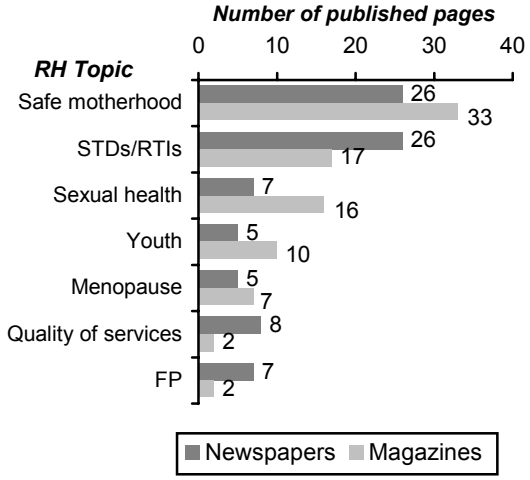
◆ The project did improve the quality of reporting, but room for further improvement remains. Roughly one in three articles based on the press briefings cited research findings or information included in the press kit. Although project staff stressed the need to use multiple sources, most articles were based on a single source of information.

RH Topics Covered in Newspapers and Magazines



◆ Of the total pages devoted to RH topics, more than one in four dealt with safe motherhood. The second most popular topic was reproductive tract infections, followed by sexual health, youth, menopause, and quality of services (see Figure).

◆ The majority of RH newspaper articles were news stories. In contrast, more than half of the magazine articles were feature stories; half of these articles were one page or longer. Both media formats are useful for research dissemination: newspapers are widely read by policymakers, while magazines tend to be shared with others and retained for a long time.

Policy Implications

◆ Research dissemination should include briefings and resource materials for journalists. Links with both print and broadcast journalists should be developed.

◆ To broaden the range of RH topics presented, more local agencies should be involved in media relations activities. More information about family planning and female genital cutting* should be provided to journalists, since these topics currently receive little press coverage.

◆ Health agencies should seek to improve the quality of reporting by providing a regular flow of accurate information and helping journalists to identify newsworthy stories.

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*See *OR Summary* 14, NGOs Need to Join Forces to End FGC.

Hegazi, Sahar and Mona Khalifa. 2000. Increasing the Coverage of Reproductive Health Issues in the Egyptian Press: Final Report. *For more information or to obtain a copy of the English Final Report of this study, contact: Population Council, 6A Giza St.,P.O. Box 115, Dokki 12211, Giza, Cairo, Egypt. Tel.: 20-2-5725910; Fax: 20-2-5701804; E-mail:* **frontiers@pccairo.org** .

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◆ After the intervention, physicians shifted from nearly universal use of dilatation and curettage (D&C) to use of MVA in 57 percent of cases requiring emergency medical treatment. More than three in four physicians reported lower complication rates with MVA, compared with D&C. More than half said that MVA is more effective and easier to use than D&C.

◆ The shift to MVA led to a shift from general anesthesia to local anesthesia in about 30 percent of the cases. Following the intervention, the proportion of physicians stating that mild analgesia and local anesthesia can reduce patients' anxiety increased significantly. However, pain control techniques still need improvement:
18 percent of post-intervention patients did not receive any pain control medication. Although the proportion of patients reporting extreme pain did not increase significantly, reports of moderate pain increased five-fold (from 5% to 27%).

◆ Nearly three in four (73%) of the post-intervention PAC patients stated that the service they received at the hospital was excellent, compared with 44 percent before the intervention. Post-intervention patients were more likely than pre-intervention patients to report that the provider was friendly, that they waited less than 30 minutes for medical services, and that they received information about possible complications, their management, and follow-up.

◆ The proportion of PAC patients who said that they had received family planning information at the hospital increased from 35 percent to 47 percent. However, only 7 percent of the PAC patients received a contraceptive method before discharge.

Policy Implications

◆ Training and protocols for PAC, including procedures for control of pain and infection and family planning counseling and services, should be standardized in hospitals as well as undergraduate and graduate medical schools. Government and teaching hospitals should include MVA supplies as standard items in their budget and should ensure an adequate supply of pain medication.

◆ Some aspects of PAC still need improvement: pain control, information given to patients, and the provision of FP counseling and services. Nurses should be given a greater role in comforting, counseling, and informing PAC patients. Simple guides on MVA instruments and FP counseling should be developed.

Utilization

◆ The Ministry of Health and Population's "Healthy Mother/Healthy Child" project is training providers in MVA and other elements of PAC, including pain control and referral to family planning services. Ten new hospitals have introduced improved PAC through the Healthy Mother/Healthy Child project—five in Aswan, two in Luxor, and three in South Qena. Expansion into new sites in Fayoum and Bani Sewef is underway.

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Nawar, Laila et al., 1997. Scaling-up Improved Postabortion Care in Egypt: Introduction to University and Ministry of Health and Population Hospitals. *For more information, contact: Population Council, 6A Mohamed Bahie Eddine Barakat St., 10th floor, Giza, Egypt. Tel. 20-2-571-9252; Fax 20-2-570-1804; E-mail: frontiers@pccairo.org.*

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